MEDICAL COVERAGE FOR CHILDREN IN FOSTER CARE

MEDICAL COVERAGE FOR CHILDREN INFOSTER CARE

CONTENTS

Page

ELIGIBILITY DETERMINATION 1
Responsibilities of Service and Income Maintenance 1
Application Process 4
Child Already Receiving Medicaid 5
Child Not Receiving Medicaid 6
Time Limit for Decision 7
Summary of Application Processing 9
Reviews 13

COVERAGE GROUPS 14
ADC-Related Eligibility 14
SSI-Related Eligibility 17
Refugee Eligibility 17
State-Funded Eligibility 18

COVERAGE FOR INTERSTATE PLACEMENTS 19
Non-IV-E Children Placed Outside Iowa 19
IV-E Children Placed Outside Iowa 20
Children Placed in Iowa by Another State 22

USE OF OTHER MEDICAL RESOURCES 23

COVERED SERVICES 24
Routine Examinations 25
AIDS Screening 26
Emergency Care 26
Managed Health Care Options 27
Transportation to Receive Medical Care 28
Psychiatric Medical Institutions for Children 29
Certification of Need for Care 30
Initial Decision on Level of Care 30b
Initial Medicaid Eligibility 32
Client Participation 34
Child’s Personal Allowance 35
IFMC Level of Care Review 36
Medicaid Eligibility Review 36
Temporary Absences 37
Runaway or Unplanned Discharge 38
Planned Discharge 39
Payment-Only Cases 40
Waiver Respite Care 40

SERVICES NOT COVERED BY MEDICAID 42
Child Hospitalized Before Placement 42

MEDICAL COVERAGE FOR CHILDREN IN FOSTER CARE

This chapter addresses the procedures required to determine Medicaid eligibility and authorize Medicaid coverage for children in foster care. Income maintenance responsibilities mentioned in this chapter are addressed in more detail in VIII-H, "Children in Foster Care and Subsidized Adoption."

Medicaid services which require special procedures by Department staff are also addressed in this chapter, as well as procedures for meeting medical needs not covered by Medicaid.

ELIGIBILITY DETERMINATION

Policy

Medicaid shall be available to persons under age 21 living in a licensed foster care facility for whom the Department has financial responsibility in whole or in part. State-funded Medicaid shall be available to children who are not eligible for federal Medicaid financial participation.

Medicaid shall also be provided to IV-E-eligible children who have been placed in Iowa by another state.

Comment

See XIII-J, FINANCIAL ELIGIBILITY FOR FOSTER CARE, for more information on how the Department becomes financially responsible for a child in foster care.

Even though every child in a foster care placement receives Medicaid, the Department must examine the child's circumstances to determine what funding source is used to pay for the child's medical care. Children must meet the eligibility criteria of Title XIX of the Social Security Act to receive federal Medicaid funding. The cost of medical services for children who do not meet these criteria is covered with 100% state dollars.

Policies governing Medicaid are covered in detail in Title VIII.

Legal reference: IAC 441--75.1(10)

Responsibilities of Service and Income Maintenance

Policy

Determining Medicaid eligibility for children in foster care placements is a cooperative effort between the service worker and the income maintenance (IM) worker. The IM worker is responsible for determining the proper coverage group and funding source. The service worker is responsible for ensuring that the information necessary to make the determination is provided to the IM worker.

MEDICAL COVERAGE FOR CHILDREN IN FOSTER CARE

ELIGIBILITY DETERMINATION (Cont.)

Responsibilities of Service and Income Maintenance (Cont.)

Comment

The IM duties related to foster care Medicaid are handled by a specialized worker on the district office staff.

Responsibility for Medicaid
Eligibility for Children in Foster Care

Duties of Service Staff	Duties of IM Staff
1. Open a service ABC case (including cases for which no maintenance payment will be made). Send Exchange of Information to the IM worker immediately if child is receiving Medicaid.	1. Open a medical case on ABC with an FBU of 19.
2. Send a foster care Medicaid application to the child's parents or other responsible person. Request return within five working days. (Note: A new application is not required when the child is already receiving Medicaid.)	2. Pend the application if one was required.
3. Date-stamp applications when returned. If application is not returned in five days, contact the parents to get it.	3. If an application was not required, obtain a copy of the most recent application and review form or SDX from the county office.
4. Complete the application on behalf of the child if necessary.	4. Determine eligibility under the IV-E coverage group.
5. Apply for a Social Security number for the child if the child does not have one (or see that the parents apply).	5. If eligibility does not exist under the IV-E coverage group, determine Medicaid eligibility under all other federally funded coverage groups.
	6. Grant Medicaid with state-only funding when there is no eligibility under a coverage group with federal financial participation.
	7. Notify the service worker of the Medicaid coverage group and IV-E eligibility via the Exchange of Information form.

MEDICAL COVERAGE FOR CHILDREN IN FOSTER CARE

ELIGIBILITY DETERMINATION (Cont.)

Responsibilities of Service and Income Maintenance (Cont.)

Comment (Cont.)

6. Complete *Exchange of Information* and forward to the IM worker and to FCRU with application within two working days of its receipt. Provide a copy of the court order or *Voluntary Placement Agreement* and form SS-2103-4.

7. Change the payee to the Department on any unearned income received by the child and send Exchange of Information to Foster Care Accounting Unit.

8. Assist the IM worker with verification needed to establish eligibility when necessary.

9. If the child is disabled, apply for SSI on the child's behalf, or ensure that the parents apply.

10. Report changes to the IM worker and to FCRU. (Includes changes in placement, maintenance payment, income, resources, deprivation, pregnancy, siblings placed together, etc.)

11. Assist IM worker with reviews of eligibility when necessary.

12. EPSDT activities.

13. Initiate medical transportation payments through ABC entries (or by *Claim Order/Claim Voucher* for child on state-only Medicaid).

8. Make referrals to CSRU on cases where the child is included on a case with the family at home.

9. Act on changes reported by the service worker and others.

10. Complete an automatic redetermination when the child becomes ineligible under the current coverage group.

11. Complete reviews.

12. Inform the service worker of changes via the Exchange of Information form.

MEDICAL COVERAGE FOR CHILDREN IN FOSTER CARE

ELIGIBILITY DETERMINATION (Cont.)

Application Process

Policy

In accordance with policies in VIII-A, an application shall be required to determine whether there is initial eligibility for Medicaid under a federally funded eligibility group and when there has been a significant change in the child's circumstances.

Comment

Medicaid rules require an application for all cases. An application shall be required for children who are court-ordered into foster care for a temporary period. These children shall be eligible for Medicaid for the month or months that they were in foster care.

When a child is placed in foster care for any length of time, even overnight, the child is eligible for Medicaid payment of medical bills. Medicaid covers the whole calendar month when the person was eligible at any time during the month.

The information on the application is necessary to determine whether the child is eligible to receive coverage under an ADC-related or SSI-related Medicaid coverage group for which the state receives federal financial participation. For an initial application, Medicaid eligibility is also evaluated for a three-month retroactive period.

Legal reference: IAC 441--76.1(249A) and 76.2(249A)

Procedure

When a child enters foster care placement, the service worker shall immediately establish a service ABC case, according to instructions found in XIV-B(5). This includes cases where no maintenance payment will be issued on ABC. A medical participation code entry is not necessary.

The service worker shall notify the appropriate IM worker of the foster care placement via the Exchange of Information, form 470-2708, immediately when the child is already receiving Medicaid. For children not receiving Medicaid, the service worker shall send the form within two working days after the application is completed. The eligibility determination is based on the living arrangement, length of placement, and where the child will go after the current placement is terminated. The IM worker obtains this information from the application and the Exchange of Information.

MEDICAL COVERAGE FOR CHILDREN IN FOSTER CARE

ELIGIBILITY DETERMINATION (Cont.)

Application Process (Cont.)

Procedure (Cont.)

Service workers shall relay changes in payment or other eligibility factors to the IM worker within two working days via form 470-2708. A sample of this form and instructions for its completion are found in XIII-J Appendix.

Child Already Receiving Medicaid

Policy

When the child is already receiving Medicaid in the month of placement, a new application shall not be required, unless it is needed as part of the automatic redetermination process.

Comment

The child could be on ADC or be receiving Medicaid under an ADC-related coverage group with other members of the child's family. If the child has already been determined to be disabled, the child could be receiving SSI or SSI-related Medicaid.

Legal reference: IAC 441--76.11(2)

Procedure

When the child is receiving Medicaid at the time of placement, the service worker shall complete the Exchange of Information, form 470-2708, and send it to the IM worker with a copy of the court order or voluntary placement agreement. The social worker shall enter a IV-E code on the service ABC case at the time of placement when it is verified that the child comes from an ADC household; meets all of the IV-E service standards as outlined in IV-E Foster Care Service Standards, form SS-2103-4; and the child's monthly income does not exceed the monthly foster care payment.

The IM worker shall complete an automatic redetermination to determine the effect of the placement on the child's Medicaid eligibility (if any).

In counties where managed health care is mandatory (see Managed Health Care Options), the social worker should contact the IM worker to determine if the child is enrolled in managed health care (MediPASS or

MEDICAL COVERAGE FOR CHILDREN IN FOSTER CARE

ELIGIBILITY DETERMINATION (Cont.)

Application Process (Cont.)

Child Already Receiving Medicaid (Cont.)

Procedure (Cont.)

HMO). If the child is enrolled in managed health care, the social worker shall give the name and phone number of the managed health care provider to the foster care provider.

Managed health care coverage continues until the first of the month after the ABC service case is opened (or the second month, if opened after cutoff). In order for any other Medicaid provider to receive payment for services, the managed health care provider must be contacted for a referral and billing number. Failure to follow this procedure will result in nonpayment of the medical bills.

Child Not Receiving Medicaid

Policy

Form 470-2779, *Foster Care Medicaid Application*, shall be completed for a child entering foster care who is not already receiving Medicaid.

Comment

The application shall be completed by the child's parents or someone else acting on the child's behalf whenever possible. (When the child is in a foster care independent living placement, the child shall complete the application.) However, when the parents or other responsible person cannot be located or fails to cooperate, the service worker or juvenile court officer shall complete the application on behalf of the child with as much information as is known. The child may assist in the application process if the child is old enough to provide information to the service worker.

Legal reference: IAC 441--76.1(249A)

Procedure

The service worker shall obtain the application before placement whenever possible. For example, when a child is in a voluntary placement, the service worker shall obtain the application as part of the voluntary placement process. For all other placements, the service worker or juvenile court officer shall send the application to the parents

MEDICAL COVERAGE FOR CHILDREN IN FOSTER CARE

ELIGIBILITY DETERMINATION (Cont.)

Application Process (Cont.)

Child Not Receiving Medicaid (Cont.)

Procedure (Cont.)

within three working days after the child is placed and request that it be completed and returned within five working days. (The application may also be mailed to the child's guardian, relative, guardian ad litem, or attorney to apply on the child's behalf.)

All applications shall be date-stamped with the date they are received by the local office (or completed by the social worker).

If the parents of the child or other responsible persons cannot be located or fail to cooperate and there is no other person representing the child, the service worker or the juvenile court officer shall complete the application on behalf of the child with as much information as is known.

The service worker or juvenile court officer shall forward the application to the appropriate IM worker within two working days after its return. The service worker shall include as much information as the service worker is able to obtain and shall attach form 470-2708, Exchange of Information, and a copy of the court order or voluntary placement agreement.

Time Limit for Decision

Policy

IM workers shall process applications within 30 days from the date the application is received in the local office. Time frames may vary depending upon the coverage group for which eligibility is being examined. Additional time may be allowed when the Department is attempting to obtain information necessary to establish eligibility. However, if information necessary to determine eligibility under a federally funded Medicaid coverage group cannot be obtained and 60 days have elapsed since the date of the filing of the application, Medicaid coverage shall be granted with state funding only.

Comment

The IM worker shall determine the Medicaid eligibility for a child in a foster care placement based on information obtained from the application. The IM worker will generate a Medical Assistance Eligibility

MEDICAL COVERAGE FOR CHILDREN IN FOSTER CARE

ELIGIBILITY DETERMINATION (Cont.)

Application Process (Cont.)

Time Limit for Decision (Cont.)

Comment (Cont.)

Card through the ABC system when the eligibility decision is reached. In some cases, this could be 30-60 days after the application is received in the local office.

Procedure

Before a medical card is issued, the service worker shall provide the foster care provider with 470-2747, *Foster Care Provider Medical Letter*. This form explains that the Department is responsible for providing medical care for the foster child and provides information needed before medical service can be obtained. If the child received Medicaid before placement, the service worker shall obtain the state ID number from the ABC system. In all other cases, the state ID is assigned when the service ABC case is opened.

When the application is received from the service worker, the IM worker shall establish a medical case with an FBU of 19 and pend the application. There must be an active service ABC case in order for a medical case with an FBU of 19 to be processed in the ABC System.

When any additional information is needed to determine eligibility under a federally funded Medicaid coverage group, the IM worker shall request it in writing from the parent, guardian, or other responsible persons representing the child. The IM worker will send a copy of the request to the service worker. If the IM worker is unable to get the necessary information, the IM worker will request that the service worker try to obtain it.

If eligibility is not determined while the child is in foster care, and the child returns home, the child's medical eligibility will be considered with the parents at home. If the child is not eligible for federal financial participation with the parents, the child shall be granted eligibility with state-only funding. If the foster care Medicaid application has been completed and the child has returned home, the social worker shall assist the IM worker in obtaining the information needed to determine Medicaid eligibility for the family.

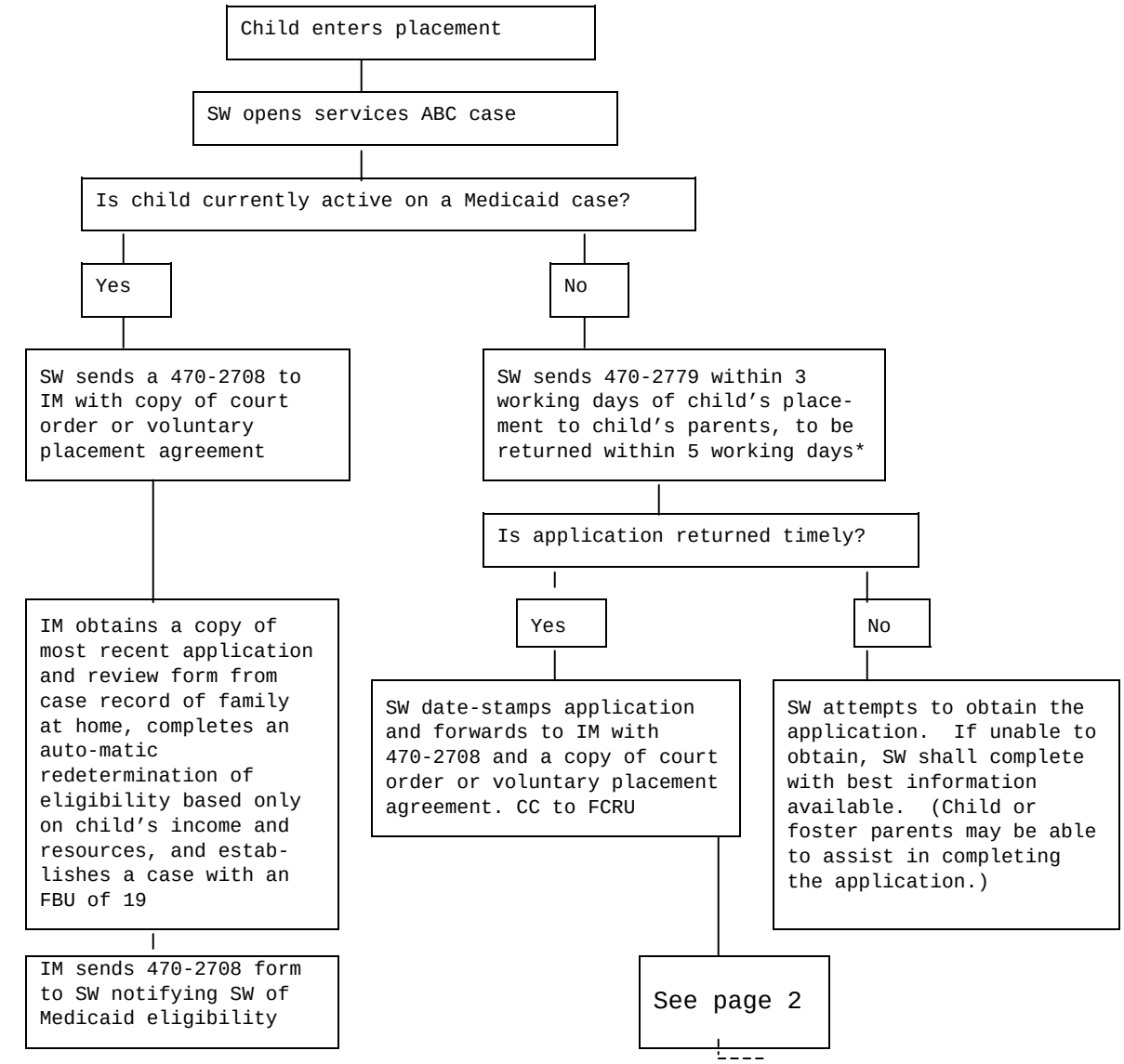
The IM worker will notify the service worker of the Medicaid coverage group via the Exchange of Information form.

MEDICAL COVERAGE FOR CHILDREN IN FOSTER CARE

ELIGIBILITY DETERMINATION (Cont.)

Summary of Application Processing

DETERMINING MEDICAID ELIGIBILITY FOR CHILDREN ENTERING PLACEMENT



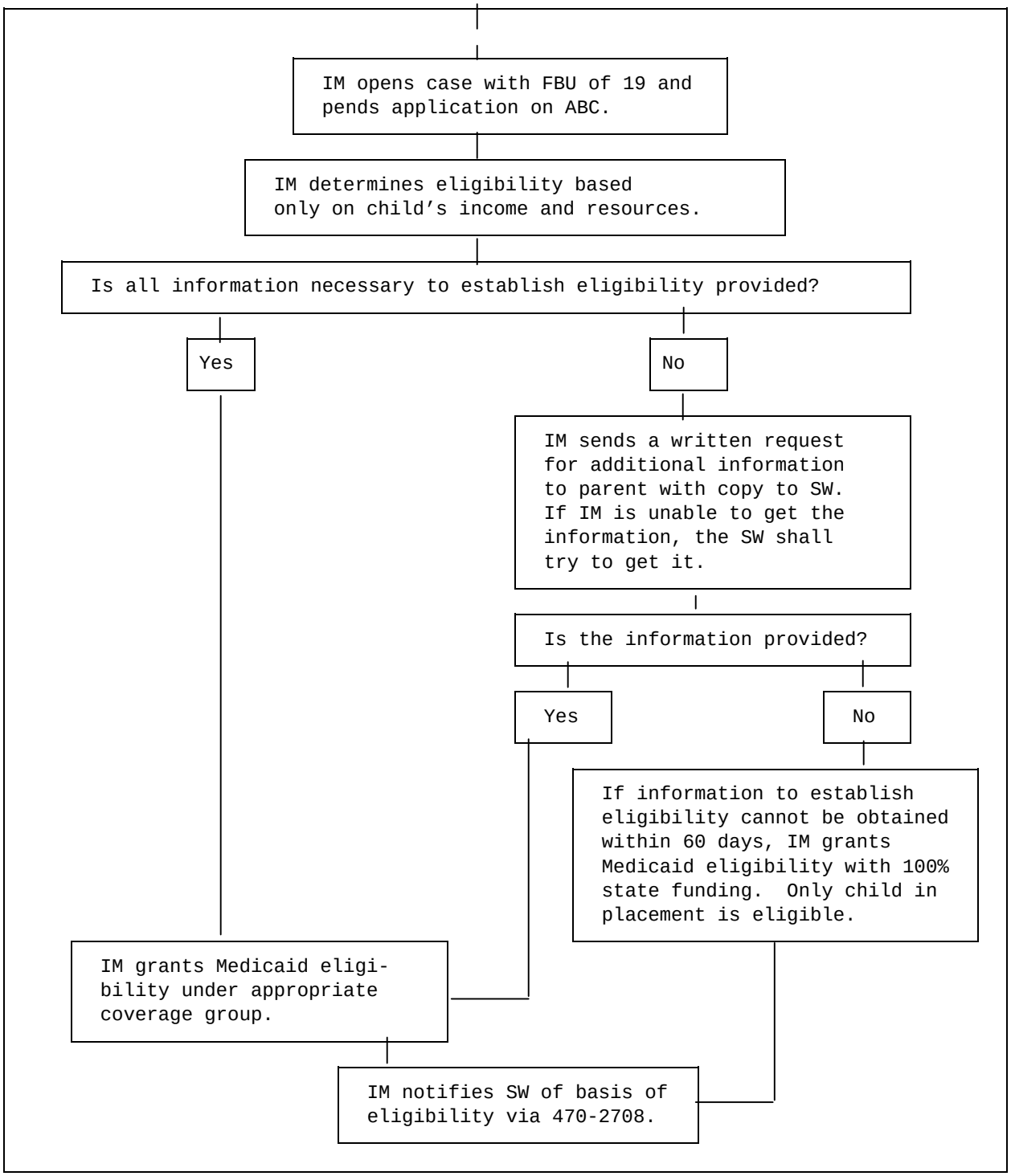
SW - Department social worker
IM - Income maintenance worker who determined Medicaid eligibility for children in foster care placement will be assigned by the area office.
(For PMIC cases, the IM case is carried by the office in the county where, the facility is located.)

*For payment-only cases, the juvenile court officer shall obtain the application and provide information, instead of the SW.

MEDICAL COVERAGE FOR CHILDREN IN FOSTER CARE

ELIGIBILITY DETERMINATION (Cont.)

Summary of Application Processing (Cont.)



MEDICAL COVERAGE FOR CHILDREN IN FOSTER CARE

Reserved for future use.

MEDICAL COVERAGE FOR CHILDREN IN FOSTER CARE

Reserved for future use.

MEDICAL COVERAGE FOR CHILDREN IN FOSTER CARE

ELIGIBILITY DETERMINATION (Cont.)

Reviews

Policy

Reviews of IV-E eligibility for children in foster care shall be conducted every six months or when there is a change in the child's circumstances that may affect the IV-E eligibility of a child in a foster care placement.

When the child is not IV-E-eligible and is receiving Medicaid with federal financial participation, reviews shall be conducted according to the policies governing the specific coverage group under which Medicaid is being provided.

When the child is receiving Medicaid with 100% state dollars, reviews shall be conducted every six months or when there is a change in the child's circumstances that may allow the child to be determined eligible under a Medicaid coverage group for which federal financial participation is available.

Comment

Whenever possible, the Medicaid review should coincide with the service review. However, reviews of Medicaid eligibility shall not be delayed past the regularly scheduled review in order to coincide with the service review.

The following chart illustrates when reviews are required by the various programs.

Coverage Group	Review Due
IV-E (other than placement made by another state)	Every six months
IV-E children placed in Iowa by another state	Annually
CMAP	Every six months
MAC	Every six months
Medically Needy	Every six months
SSI	Annually (by the Social Security Administration)
URM	Annually
State-only coverage	Every six months

MEDICAL COVERAGE FOR CHILDREN IN FOSTER CARE

ELIGIBILITY DETERMINATION (Cont.)

Reviews (Cont.)

Comment (Cont.)

In addition to the time frames specified, eligibility shall be redetermined when there are changes in the child's circumstances that may affect eligibility. Changes that may affect eligibility include, but are not limited to, changes in income, resources, living arrangement, or length of placement, and pregnancy.

A child can retain eligibility for Medicaid during a temporary absence from foster care. If a child who is receiving Medicaid with federal financial participation leaves foster care, the IM worker shall complete an automatic redetermination of eligibility.

Legal reference: 441 76.7(249A)

Procedure

The ABC System automatically issues the *Public Assistance Eligibility Report (PAER)*, form PA-2140-0, before a Medicaid eligibility review is due on any aid types except SSI. The PAER will be mailed to the same address as the medical card, i.e., to the foster care provider. (This is mentioned in the *Foster Care Provider Medical Letter*, form 470-2747.)

Review forms shall be completed by the parents, by the child, or by a responsible person acting on the child's behalf. When the parent or responsible person fails to complete the review form, the service worker shall complete and return the form to the IM worker. See XIII-J-Appendix for instructions.

COVERAGE GROUPS

ADC-Related Eligibility

Policy

Children in foster care may attain federal Medicaid eligibility through an ADC-related coverage group.

Comment

Following is a description of the various coverage groups under which a child may qualify:

MEDICAL COVERAGE FOR CHILDREN IN FOSTER CARE

COVERAGE GROUPS (Cont.)

ADC-Related Eligibility (Cont.)

Comment (Cont.)

1. ADC

When a child receiving ADC leaves home and enters foster care, the child is removed from the ADC grant with the family and receives Medicaid based only on the child's income and resources. A child currently receiving ADC cannot receive IV-E foster care payments.

2. IV-E

IV-E eligibility is based on the financial and nonfinancial requirements of the ADC program (found in Title IV-A of the Social Security Act). When IV-E eligibility is granted, the cost of both the maintenance payment and the Medicaid coverage are supported with both state and federal funding.

3. Child Medical Assistance Program (CMAP)

Medicaid shall be available to children in foster care and subsidized adoption placements who are not IV-E eligible, who are under age 21, and whose income and resources, including Medicaid qualifying trusts, do not exceed ADC limits.

All children in a foster care placement are considered as living apart from the parent. The child shall be considered a unit of one unless the child is living with siblings in the foster home.

4. Mothers and Children (MAC)

Children in foster care cannot be considered a part of the family unit. Medicaid shall be available to persons who are pregnant whose countable income does not exceed 185% of the federal poverty level and to the following children in foster care, who are not IV-E-eligible, when their countable income and resources do not exceed the established limits:

a. Infants (under one year of age), when the countable income does not exceed 185% of the federal poverty level.

MEDICAL COVERAGE FOR CHILDREN IN FOSTER CARE

COVERAGE GROUPS (Cont.)

ADC-Related Eligibility (Cont.)

Comment (Cont.)

b. Children who have attained age one but who have not attained age six, when the countable income does not exceed 133% of the federal poverty level.

c. Children who have attained age six but who have not attained age nineteen and who were born after September 30, 1983, when the countable income does not exceed 100% of the federal poverty level.

5. Medically Needy

Medicaid shall be available through the medically needy program to all children in a foster care or subsidized adoption placement who are not IV-E eligible, who are under the age of 21, and who would be eligible for an ADC-related Medicaid coverage group except for excess income or resources.

Coverage under the medically needy program shall not be provided to children in foster care or subsidized adoption placements who would be eligible under these provisions only if they met a spenddown. If the child is required to meet a spenddown, Medicaid shall be provided with 100% state funding.

Legal reference: IAC 441--75.1(1), 75.1(10), 75.1(15), and 75.1(18) and IAC 441--86

Procedure

The IV-E program has both service and financial eligibility requirements. Therefore, the eligibility determination is a joint process involving both the service worker and the IM worker. The IM worker determines financial eligibility and the service worker determines the IV-E foster care service requirements.

The service worker determines IV-E service eligibility by completing *Foster Care Service Standards*, form SS-2103-4. The completed form is sent to the IM worker attached to the *Exchange of Information*, form 470-2708.

The service worker shall enter a IV-E aid type on the service ABC case effective the first of the month following placement when it is verified at the time of placement that the child came from an ADC household and meets all of the IV-E service standards.

MEDICAL COVERAGE FOR CHILDREN IN FOSTER CARE

COVERAGE GROUPS (Cont.)

SSI-Related Eligibility

Policy

Medicaid shall be provided to children in foster care who receive assistance through the Supplemental Security Income (SSI) program due to blindness or disability or who would be eligible for SSI except for their income or resources.

Comment

SSI funding provides federal funds both for maintenance and for medical care. When a child receiving SSI is in a foster care placement, the SSI payment is assigned to the state to offset the cost of the foster care maintenance payment.

A child receiving SSI cannot be IV-E-eligible. Therefore, the maintenance payment is supported with state funding only and Medicaid eligibility is granted based on SSI eligibility. However, if a child eligible for SSI is adopted with a subsidy, that child is automatically eligible for IV-E funding for the subsidy.

Legal reference: IAC 441--75.1(4)

Procedure

When a child who is potentially eligible for SSI enters foster care, or becomes potentially eligible during placement, the service worker shall ensure that an application for SSI benefits is filed with the Social Security Administration. The service worker shall inform the IM worker of the Social Security Administration's decision on the application via the *Exchange of Information*, form 470-2708.

Refugee Eligibility

Policy

The Refugee Medical Assistance program shall be available to any child who meets the definition of "unaccompanied refugee minor" and who is under the age of 21.

MEDICAL COVERAGE FOR CHILDREN IN FOSTER CARE

COVERAGE GROUPS (Cont.)

Refugee Eligibility (Cont.)

Comment

Children entering the United States as unaccompanied refugee minors (URMs) are defined by the Immigration and Naturalization Services as children whose destination is not to a parent, a close parental relative willing and able to care for the child, or an adult with a clear and court-verifiable claim to custody of the minor.

The Refugee Medical Assistance program is funded with 100% federal funding and is available as long as the child retains URM status.

A refugee child in a service placement who is not an unaccompanied minor may also be eligible for Refugee Medical Assistance (RMA) during the first 12 months that the child is in the United States. However, before RMA coverage can be provided to refugee children who are not classified as URMs, it must first be established that they are not eligible under the Medicaid program. Refugee Resettlement funding is available to cover the state Medicaid match for the first four months that the child is in the United States.

Refer to XIII-F for additional information regarding refugees.

Legal reference: 45 CFR 400.111

Procedure

The service worker shall inform the IM worker of the child's refugee status. The IM worker shall establish the medical case under the correct funding source.

State-Funded Eligibility

Policy

Medical coverage, supported with state funding only, shall be provided to children under the age of 21 living in a licensed foster care facility for whom the Department has responsibility in whole or in part. Before medical coverage under these provisions can be provided, it must first be established that the child does not qualify to receive Medicaid under any other coverage group except medically needy with a spenddown.

MEDICAL COVERAGE FOR CHILDREN IN FOSTER CARE

COVERAGE GROUPS (Cont.)

State Funded Eligibility (Cont.)

Comment

Eligibility for all federally funded Medicaid coverage groups shall be examined before granting medical coverage supported with state funding only to a child in a foster care placement. If the only Medicaid coverage group under which the child would qualify is medically needy with a spenddown, state-only Medicaid shall be provided as a last resort.

Medicaid eligibility gained through this provision pertains only to the child in foster care. Eligibility does not extend to a child who is not in foster care, nor to a child's relatives, caretakers, or foster care providers.

Legal reference: IAC 441--75.1(10)

Procedure

The service worker shall establish the service case, and the IM worker shall establish the medical case with an FBU of 19.

A review of the child's circumstances shall be completed every six months to determine whether the child continues to be ineligible for a Medicaid coverage group for which the state could receive federal financial participation. Additionally, eligibility for federal Medicaid funding shall be evaluated whenever there is a change in the child's circumstances which affects eligibility for a federally funded coverage group.

COVERAGE FOR INTERSTATE PLACEMENTS

Non-IV-E Children Placed Outside Iowa

Policy

A non-IV-E child placed out of state shall continue to be eligible for Iowa Medicaid.

Comment

When a child receiving SSI is placed in another state, the Medicaid program in that state may cover the child. The child still can be eligible under Iowa's Medicaid program, however.

Legal reference: IAC 441--75.1(10)

MEDICAL COVERAGE FOR CHILDREN IN FOSTER CARE

COVERAGE FOR INTERSTATE PLACEMENTS (Cont.)

Non-IV-E Children Placed Outside Iowa (Cont.)

Procedure

Eligibility determination for Iowa children who are not eligible for IV-E payments is handled the same way whether the child is placed in Iowa or out of state.

If the child will be covered exclusively under the Iowa Medicaid program, the local worker shall inform the foster care provider of the need to locate providers who are (or are willing to become) Iowa Medicaid vendors. If the foster care provider is unable to locate such providers, the service worker shall contact the Division of Medical Services for assistance in locating Iowa Medicaid vendors in the community in which the child lives.

If there are no Iowa Medicaid vendors in the community, the service worker shall contact the child's medical providers and encourage them to enroll in Iowa's Medicaid program by contacting the Department's fiscal agent, Unisys, at P.O. Box 10394, Des Moines, Iowa 50306 (515-263-3984). If services must be obtained from providers that are not Iowa Medicaid vendors, see SERVICES NOT COVERED BY MEDICAID.

If a medical card is issued to the child by another state and is received in the central or local office, the worker shall send it to the child's placement in the other state.

IV-E Children Placed Outside Iowa

Policy

A IV-E child placed out of state shall be eligible for Medicaid from the state in which the child's placement is located. If the other state's Medicaid program does not cover a service needed by the child, the worker shall follow the policies and procedures under Services Not Covered by Medicaid.

Comment

Medicaid coverage from the state in which the placement is located should make it easier for the foster care provider to obtain services from medical providers in the community.

Legal reference: PL 99-272

MEDICAL COVERAGE FOR CHILDREN IN FOSTER CARE

COVERAGE FOR INTERSTATE PLACEMENTS (Cont.)

IV-E Children Placed Outside Iowa (Cont.)

Procedure

When a IV-E child is placed from Iowa into another state, the child's service worker shall do the following:

1. Indicate that the child is IV-E eligible in the upper right corner of the Interstate Compact Placement Request (ICPC-100A).

2. Discuss with the provider the fact that Medicaid coverage will be provided by the state of residence rather than Iowa because of the child's IV-E eligibility.

3. Notify the IM worker as soon as possible, so that the IM worker can complete and mail a timely Notice of Decision to the child cancelling Iowa Medicaid.

4. Write a letter to the provider indicating that Iowa will continue to make the foster care payment, but will no longer provide Medicaid coverage because the child receives IV-E foster care assistance and is now eligible for Medicaid from the state in which the facility is located, based on Public Law 99-272. Direct the foster care provider to apply for Medicaid from the appropriate local agency and indicate that the provider should contact the child's worker if there are any problems.

5. If the other state sends the Medicaid card to the Department rather than to the provider, send the card to the foster care provider. Advise the foster care provider to ask the other state to send the Medicaid card directly to the foster care provider.

6. Continue to review IV-E eligibility as required. If the child's IV-E eligibility ends, notify the foster care provider and notify the IM worker via the Exchange of Information, form 470-2708.

Comment

While IV-E eligibility is documented on form ICPC-100A, no other correspondence goes through the Interstate Compact on the Placement of Children (ICPC) because Medicaid is not under ICPC jurisdiction.

MEDICAL COVERAGE FOR CHILDREN IN FOSTER CARE

COVERAGE FOR INTERSTATE PLACEMENTS (Cont.)

Children Placed in Iowa by Another State

Policy

Medicaid shall be provided to IV-E eligible children who are placed in Iowa by another state for whom the placing state is making a IV-E maintenance payment.

Comment

Legal reference: P.L. 99-272

Procedure

When a IV-E-eligible child is placed in Iowa by another state, the service worker may not be contacted first. If not, the IM worker shall notify the service worker of the application via the Exchange of Information, form 470-2708.

If supervision is not being requested by the placing state, the service worker shall open a TD with aid type 42-9, interstate IV-E foster care, or 46-5, interstate IV-E adoption, with no maintenance payment. It is not necessary to open an SRS case if supervision is not provided. It is necessary that this corresponding ABC service case be open before a medical card can be issued.

Generally, when a IV-E eligible child is placed in Iowa, the placing state instructs the family to file an application in Iowa and provides Iowa with written verification of the child's IV-E eligibility. If no verification is provided, the IM worker shall contact the placing state to obtain a written statement to document the case record. Upon receipt of IV-E verification from the placing state and a completed application form, the IM worker is not required to make any further eligibility determination, unless the child loses IV-E eligibility in the placing state. The IM worker shall establish a medical case with an FBU of 19.

The IM worker shall review these cases annually and contact the placing state to verify that IV-E eligibility continues.

MEDICAL COVERAGE FOR CHILDREN IN FOSTER CARE

USE OF OTHER MEDICAL RESOURCES

Policy

Third-party medical resources include health and accident insurance, settlements from lawsuits, eligibility for care through Veteran's Administration, Specialized Child Health Services, Medicare, and other resources for meeting the cost of medical care which may be available to the recipient. Such resources shall be used before payment is made through the Medicaid program, except when otherwise authorized by the Department.

Comment

Medical resources include any insurance coverage available through an absent parent's employment.

See VIII-B for more information on Medicaid policies about using other medical resources before Medicaid is billed. See XIII-J(2) for other information on foster care recovery from resources such as insurance.

Legal reference: IAC 441--75.2(249A)

Procedure

Information about the family's medical resources is requested on the Medicaid application. The service worker shall document third-party resources, including health insurance coverage, on the ABC System. See XIV-B-Appendix for a list of medical resource codes.

The Medicaid fiscal agent (a private company under contract to the Department to pay Medicaid claims) requires that the other insurance be billed before Medicaid payment is determined. Service workers shall ensure that the foster care provider has information about the child's health insurance coverage. Failure to present needed insurance forms or information to the medical vendor will cause claims to be rejected.

If the child's family is unwilling to cooperate with securing payment through their insurance, Medicaid will pay the claim. To accomplish this, the medical provider shall contact the Third-Party Liability Unit in the Bureau of Medical Services. If the parents later cooperate and either they or the medical provider receive payment from the parent's insurance company, the worker shall notify the Third-Party Liability Section, so that unit can act to recover Medicaid payment.

MEDICAL COVERAGE FOR CHILDREN IN FOSTER CARE

COVERED SERVICES

Policy

Medicaid pays for services and supplies provided to eligible recipients by the following vendors under contract to the Department, within the limits of the State Medicaid Plan:

- Ambulance services
- Ambulatory surgical centers
- Area education agencies (AEAs)
- Audiologists
- Birth centers
- Chiropractors
- Community mental health centers
- Dentists
- Family planning clinics
- Family nurse practitioners
- Genetic counseling clinics
- Hearing aid dealers
- Home- and community-based waiver services
- Home-health agencies
- Hospitals
- Independent laboratories
- Intermediate care facilities
- Intermediate care facilities for the mentally retarded
- Maternal health centers
- Medical equipment
- Nurse anesthetists
- Nurse-midwives
- Opticians
- Optometrists
- Orthopedic shoes
- Pediatric nurse practitioners
- Physical therapists
- Physicians
- Podiatrists
- Prescribed drugs
- Psychiatric medical institutions for children
- Psychologists
- Rehabilitation agencies
- Rural health clinics
- Screening centers
- Skilled nursing facilities
- Transportation for medical care

Providers must agree to participate in the program. Payment is made directly to the providers of services. Reimbursement is not made to the recipient or others paying for covered services on the recipient's behalf, except for medical transportation and, in the foster care program, for certain medical expenses not covered by the Iowa Medicaid Program.

Comment

Specific limits and requirements of the Medicaid program are explained for each type of provider in provider manuals. (These manuals are included in VIII-A-Appendix(II).) In general, providers are responsible for finding out what Medicaid covers; Department field staff are ordinarily not required to provide this information. However procedures for some services, such as obtaining hearing aids, orthopedic shoes, and payment for transportation to receive medical care, require Department staff involvement and are covered in VIII-A(1). Instructions for some services commonly used for children in foster care are summarized in the following sections.

Legal reference: IAC 441--78

MEDICAL COVERAGE FOR CHILDREN IN FOSTER CARE

COVERED SERVICES (Cont.)

Routine Examinations

Policy

Children in foster care are required to have an annual routine physical examination.

After age three, children must be referred for:

1. Dental examinations and teeth cleaning every six months.

2. Vision examinations annually and as needed.

A hearing examination should be obtained if a problem is suspected. Area education agencies, physicians, and audiologists can do these examinations.

Comment

Medicaid payment policies for physical examinations are outlined in the Physicians Provider Manual and the Early and Periodic Screening, Examination, and Treatment (EPSDT) Manual. (See VIII-A-Appendix (II).)

Federal law requires states to provide EPSDT services to children under age 21. Foster care physical examinations are required more frequently than EPSDT screenings, except for children under age two.

In addition to EPSDT examinations, Medicaid will pay claims for routine physicals when the claim form is marked "foster care annual physical," "school examination," "camp examination," or "well baby care" (for children under six years of age).

If a child needs a physical to participate in sports, this should be combined with the annual physical.

Legal reference: IAC 441--78.1(1), 78.4(1)"b"

Procedure

Children under age two in foster care should participate in the EPSDT program. Recommended ages for screening are: one month, two months, four months, six months, nine months, fifteen months, eighteen months, and two years. The pamphlet THINK ME, Comm.4, explains the EPSDT program to recipients. Screening can be done by screening centers or private physicians. Instructions for EPSDT forms are found in VIII-F-Appendix.

MEDICAL COVERAGE FOR CHILDREN IN FOSTER CARE

COVERED SERVICES (Cont.)

Routine Examinations (Cont.)

Procedure (Cont.)

When Medicaid benefits are initiated, the service worker shall complete form MA-2119-0, *Referral for Screening*, for all children. The form should be signed by the child's parent or guardian as the responsible person.

The response on this form governs the entry in Field 193, health screening, on the ABC TD. If screening is accepted, the worker shall document that the examination was obtained and the results, either by a copy of the examination form or an explanation of the results. If screening is refused, the ABC System generates form MA-2125-0, *Screening Notice*, on an annual basis as a reminder.

AIDS Screening

Policy

Payment is made for HTLV III/LAV (the virus thought to cause AIDS) screening for children who are at increased risk of infection (mother used IV drugs, mother had a sex partner who used IV drugs, mother was a prostitute, child may have been sexually abused by a high-risk person) or who are syumptomatic.

Comment

Consent of the child's parent or guardian, or court order is required before the child is tested for the HTLV IIILAV virus.

Legal reference: IAC 441—78.20(249A)

Emergency Care

Policy

Payment is made for emergency services if a physician has made a referral for emergency care.

Comment

The service worker shall advise the foster care provider of the need for a physician's referral.

Legal reference: IAC 441--78.13(12)

MEDICAL COVERAGE FOR CHILDREN IN FOSTER CARE

COVERED SERVICES (CONT.)

Managed Health Care Options

Policy

Children in foster care are not eligible for Medicaid services through health maintenance organizations (HMO) or prepaid health plans unless they are still receiving an ADC grant.

Comment

Effective July 1, 1990, the following counties are mandatory managed health care counties: Black Hawk, Jackson, Linn, Muscatine, Polk, Pottawattamie, Scott. All ADC and ADC-related recipients living in those counties must choose a MediPASS manager or elect to enroll in a Medicaid contracting HMO, if there is one in their county. All children entering foster care from these counties who are already receiving Medicaid will be on some type of managed health care plan.

Additional information on HMO policy and procedure can be found in VIII-A(1), HEALTH MAINTENANCE ORGANIZATIONS.

Legal reference: IAC 441--88

Procedure

The method of Medicaid administration is set at ABC cutoff for the following month. A child receiving Medicaid who enters foster care remains on the HMO or MediPASS System.

Opening a service ABC case will trigger the child's removal from the managed health care system after the next ABC cutoff, effective the following month. This means that if the service ABC case is entered after cutoff, the child will remain in the managed health care option for an additional month.

The service worker shall ensure that the foster care provider is given the name of the managed health care provider on form 470-2747, Foster Care Provider Medical Letter. The managed health care provider must approve any medical treatment by other providers and give an authorization number to allow other providers to bill Medicaid.

MEDICAL COVERAGE FOR CHILDREN IN FOSTER CARE

COVERED SERVICES (Cont.)

Transportation to Receive Medical Care

Policy

The Medicaid program pays for transportation of a child in foster care to receive necessary medical care when:

1. The source of care is outside the community or the child lives in the country and must go to town for medical care, and

2. There is no provider of the necessary services in the community or the child has been referred by a physician to a specialist in another community, and

3. The source of care is the nearest provider of the service, and

4. The worker has established that there is no resource to provide the transportation free of charge.

Comment

Since the parents have primary responsibility for the cost of the child's care and services, the parents shall ordinarily be expected to provide the child with transportation to receive medical care at no charge. If this is not possible, the foster care provider is expected to provide transportation within the community as part of the standard payment arrangements, but is eligible for reimbursement under this provision if transportation outside the community is required.

Allowable expenses may include the actual cost of meals, parking, child care, lodging, passenger fare or mileage, at the rate granted state employees.

Legal reference: IAC 441--78.13(249A)

Procedure

The worker shall clarify what expenses are payable under this provision.

Form MA-3022-1, Medical Transportation Claim, must be completed by the child or a person acting on the child's behalf and by the medical provider for each trip for which payment is requested. All trips to the same provider in the same month may be submitted on the same form. See VIII-A(2), Transportation for Medical Care, for detailed payment information, and VIII-A-Appendix for instructions on form MA-3022-1.

MEDICAL COVERAGE FOR CHILDREN IN FOSTER CARE

COVERED SERVICES (Cont.)

Transportation to Receive Medical Care (Cont.)

Procedure (Cont.)

Payment for children eligible for federal financial participation is issued through Section IX of ABC. Payment for persons who are not federally eligible must be made through the Claim Order/Claim Voucher and charged to state medical assistance funds. See XIII-J-Appendix for instructions on completing the Claim Order/Claim Voucher.

Psychiatric Medical Institutions for Children

Policy

A child court-ordered into foster care who meets level of care criteria shall be eligible for Medicaid payment at facilities licensed as psychiatric medical institutions for children.

Comment

The Department provides Medicaid payment for foster care placements of eligible children at facilities licensed as psychiatric medical institutions for children (PMICs). See VIII-E(2), FACILITIES ELIGIBLE TO PARTICIPATE, for a list of these facilities.

Policies and procedures for PMICs in this chapter apply to court-ordered foster care placements only. If the parent or guardian of a child not under juvenile court jurisdiction contacts a Department service worker with a request to place a child into a PMIC, the service worker shall assist the family in securing court involvement.

In addition to psychiatric treatment, services provided by PMICs may include other components, such as family counseling, depending on the child's needs. PMIC units may or may not be separated from a facility's regular group foster care units. Psychiatric units shall not be locked.

For additional information regarding Medicaid policies and procedures for these facilities, see VIII-E(2).

Legal reference: 1989 Iowa Acts, S.F., 540, Section 33;
441—85.2(4) and 441—85.8(1)

MEDICAL COVERAGE FOR CHILDREN IN FOSTER CARE

COVERED SERVICES (Cont.)

Psychiatric Medical Institutions for Children (Cont.)

Procedure

Because of the complexity of Medicaid eligibility and payment procedures, both IM and service workers have responsibilities when a child court-ordered into foster care is placed into a PMIC. An IM worker (known as the facility IM worker) in the county in which the PMIC is located is designated to work with the facility.

Service workers shall continue to follow foster care policies for foster care placements in PMICs, including those regarding foster care visits, case permanency plans, and six-month foster care administrative reviews.

The service and facility IM workers shall communicate with each other using form 470-2470, PMIC Exchange of Information. When a court-ordered foster care child is to be or has been placed in a PMIC, psychiatric medical institution, Medicaid eligibility must be determined. This involves both a determination of medical necessity and a determination of financial eligibility.

Modification of the court order is not necessary if the current order is for group foster care or residential treatment, because4 the law states that care furnished by PMICs shall continue to be considered foster care. However, the service worker shall notify the court, the child’s parents and all interested parties identified on the case permanency plan regarding the child’s placement into a PMIC.

Certification of Need for Care

Policy

An independent team shall certify that inpatient services can be reasonably expected to improve the person’s condition or prevent further regression, so that ongoing impatient services eventually will no longer be required, and that outpatient services are not presently a viable alternative.

1. A preadmission evaluation shall be performed within 45 days prior to the proposed date for admission to the facility. The evaluation shall be submitted to the institution on or before the date of the person’s admission.

2. For emergency admissions, a certification shall be provided by the interdisciplinary team of physicians and other personnel employed by the facility responsible for the plan within 14 days after admission.

MEDICAL COVERAGE FOR CHILDREN IN FOSTER CARE

COVERED SERVICES (Cont.)

Psychiatric Medical Institutions for Children (Cont.)

Certification of Need for Care (Cont.)

Policy (Cont.)

3. When a person applies for Medicaid after admission, a certification by the tam responsible for care shall be provided and cover any period prior to application for which claims are to be made.

Comment

The preadmission evaluation may be performed by a community mental health center. Failure to have a preadmission evaluation does not preclude admission to the facility but does preclude Medicaid payment (except for emergency admissions). Therefore, facilities may refuse admission if the preadmission evaluation has not been performed.

An emergency admission is defined as admission to provide care required after the sudden onset of a medical condition with acute symptoms of such severity that absence of immediate medical attention could reasonably result in:

1. Placing the child’s health in serious jeopardy, or

2. Serious impairment to the child’s bodily functions, or

3. Serious dysfunction of any of the child’s bodily organs.

Legal reference: Iowa Administrative Code 441—85.2(3); 42 CFR 441.152

Procedure

Service workers seeking admission for a Medicaid-eligible child to a PMIC (or MHI) shall ensure that the child has a preadmission evaluation made by a team that is independent of the facility. At a minimum, the team must consist of a physician who has competence in the diagnosis and treatment of mental illness and has knowledge of the child’s situation, and at least one other professional. The other professional may be a Department service worker or a juvenile court officer. The team must certify that:

1. Outpatient services available in the community do not meet the treatment needs of the child, and

MEDICAL COVERAGE FOR CHILDREN IN FOSTER CARE

COVERED SERVICES (Cont.)

Psychiatric Medical Institutions for Children (Cont.)

Certification of Need for Care (Cont.)

Procedure (Cont.)

2. The child needs inpatient care under the direction of a physician, and

3. The admission is expected to improve the child's condition or pre-vent further regression so that ongoing inpatient services will no longer be required.

A specific form is not required for this certification. However, form 470-2780, Certification of Need for Inpatient Psychiatric Services, may be used.

Initial Decision on Level of Care

Policy

The Iowa Foundation for Medical care shall determine the medical necessity for admission to a PMIC. Medicaid payment shall not be made for admissions which are determined not to be medially necessary.

Comment

The Iowa Foundation for Medical Care (IFMC) is the peer review organization under contract with the Department. IFMC determines whether a foster care child is eligible for Medicaid payment for the level of care provided by a PMIC. IFMC determines the child's eligibility based on the child's medical records submitted to the facility. Some of the issues considered include the child's mental status; behavior; social, vocational and educational skills; treatment needs; medical status; physical status; daily living skills; appropriateness of services being provided; and discharge planning.

MEDICAL COVERAGE FOR CHILDREN IN FOSTER CARE

COVERED SERVICES (Cont.)

Psychiatric Medical Institutions for Children (Cont.)

Initial Decision on Level of Care (Cont)

Comment (Cont.)

Payment can be made through the Medicaid program only if IFMC approves the child's eligibility for the level of care provided by a PMIC. If IFMC determines that a foster care child needs this level of care, payment can be made through he Medicaid program at the Medicaid rate.

If IFMC denies the child's eligibility for the level of care provided by a PMIC, payment cannot be made at the Medicaid rate. If the facility has a purchase of service contract to provide group foster care, payment can be made through the foster care program at the foster care rate in the facility's purchase of service contract. If the facility does not have a purchase of service agreement for foster group care, the service worker cannot make a foster care placement in the facility. The service worker must then negotiate a different placement.

Legal reference: IAC 441—85.8(1)

Procedure

Before placement, the service worker shall contact the facility to make a placement referral. The referral shall include available medical records. If the court has placed the child in the facility before the Department is aware of the case, this step can be omitted, although the service worker may need to provide available medical records.

The facility contacts IFMC, and IFMC determines whether the child needs PMIC care and communicates his to the facility. The facility reports the result to the service worker. The facility also prepares form AA-4166-0, Case Activity Report, and sends this report to the IM worker assigned to the facility. This report notifies the facility IM worker whether the level of care has been approved. The facility IM worker sends a copy of the Case Activity Report to the service worker assigned to the case.

If IFMC determines that the child needs PMIC, the service worker can place the child in the facility. If the Department has custody or guardianship of the child, the service worker shall complete form 470-2490, Placement Agreement: Specialized Psychiatric Institution, and secure necessary signatures. The worker shall send a copy of form 470-2490 to the Foster Care Accounting Unit in the Bureau of Finance.

MEDICAL COVERAGE FOR CHILDREN IN FOSTER CARE

COVERED SERVICES (Cont.)

Psychiatric Medical Institutions for Children (Cont.)

Initial Decision on Level of Care (Cont)

Procedure (Cont.)

The service worker shall revise the child's case permanency plan to reflect changes in placement and responsibilities, and provide the facility with a copy of the child's case permanency plan. The service worker shall also change the B29 service to F29 on the service line of SRS and terminate any foster care payment being made on the ABC TD.

Initial Medicaid Eligibility

Policy

The facility IM worker shall determine whether a child who qualifies for PMIC care is eligible for federal Medicaid funding.

If the child is expected to return home in less than 12 months, both the parents and child's income and resources are considered in determining eligibility for ADC-related Medicaid. If the child is expected to be out of the home longer than 12 months, only the child's income and resources are considered.

When a child is court-ordered into foster care and is eligible for this level of care, but is not eligible for federal Medicaid funding, the care is paid from 100% state funds.

Comment

IV-E eligible children placed by another state into Iowa are eligible for Medicaid coverage by Iowa when a IV-E maintenance payment is being made on their behalf. They are not eligible for Iowa Medicaid payment for care at a PMIC because no IV-E foster care maintenance payment is made.

Legal reference: IAC 441—85.2(4); 75.1(2), 75.1(15), and 75.1(17)

Procedure

Immediately upon placement, the service worker shall notify the foster care IM worker (if any) by form 470-2708, Exchange of Information, and the facility IM worker through form 470-2479, PMIC Exchange of Information. The foster care IM worker will send the facility IM worker a copy of the most recent application or review form.

MEDICAL COVERAGE FOR CHILDREN IN FOSTER CARE

COVERED SERVICES (Cont.)

Psychiatric Medical Institutions for Children (Cont.)

Initial Medicaid Eligibility (Cont)

Procedure (Cont.)

If the child is not in foster care and is not receiving Medicaid, the service worker is responsible for seeing that the child's family completes a Medicaid application. Use form PA-2207-0, Public Assistance Application, if the child will be out of the home three months or less. Use form 470-2779, Foster Care Medicaid Application, if the child will be out of the home longer than three months. If the child's family is unable or unwilling to complete the application within five working days of the date of the service worker's request, the service worker shall complete the application to the best of the worker's ability.

The service worker shall provide the completed application to the facility IM worker and to the PLD specialist (or to the Foster Care Recovery Unit for those counties not served by a PLD specialist), along with form 470-2479, PMIC Exchange of Information, and a copy of the court order. In all cases, the service worker shall indicate on form 470-2479 the best estimate of the date the child will return home and who should receive notice of Medicaid eligibility.

The facility IM worker verifies income and resource information. When this involves correspondence with the child's parents, the IM worker sends a copy of all correspondence to the child's service worker. Within 30 days of receiving the application, the facility IM worker determines whether the child is eligible for federal financial participation through Medicaid. The IM worker then opens an ABC case to pay the facility for the child's care.

If the child is eligible for Medicaid federal funding, the facility IM worker codes for payment from Medicaid. If the child is not eligible for Medicaid, but the child is court-ordered into group foster care, the facility IM worker codes for payment with 100% state funds.

The IM worker notifies the service worker and the Bureau of Finance of the child's Medicaid eligibility, using form 470-2479, PMIC Exchange of Information. Notice is sent to the person designated by the service worker.

The PLD specialist handles the assignment of court-ordered child support.

MEDICAL COVERAGE FOR CHILDREN IN FOSTER CARE

COVERED SERVICES (Cont.)

Psychiatric Medical Institutions for Children (Cont.)

Client Participation

Policy

Client participation shall be determined when a foster care child receiving care in a PMIC has income.

Comment

Client participation in the cost of care is required by Medicaid if a child has income in excess of a personal needs allowance.

Income available for client participation includes the child's earned and unearned income and court-ordered child support. With respect to child support, only actual payments are considered income for client participation, rather than the court-ordered assessment. Parental liability is not assessed when a child is placed in a PMIC.

Legal reference: IAC 441—85.4(1)

Procedure

The service worker shall follow the procedures in XIII-J(2) to have DHS named payee for the child's unearned income and court-ordered support.

The facility IM worker obtains information on earned and unearned income and on insurance coverage from form PA-2207-0, Public Assistance Application; form 470-2779, Foster Care Medicaid Application; or the SDX.

The service worker shall use form 470-2479, PMIC Exchange of Information, to notify the facility IM worker of:

1. The amount of any court-ordered child support and the name of the payee (and, if the Department is not the payee, whether a change in payee has been requested);

2. Any changes in earned or unearned income, insurance coverage, or child support, of which the service worker becomes aware.

MEDICAL COVERAGE FOR CHILDREN IN FOSTER CARE

COVERED SERVICES (Cont.)

Psychiatric Medical Institutions for Children (Cont.)

Client Participation (Cont.)

Procedure (Cont.)

When the Department is payee for the child's unearned income, the Department forwards the child's personal allowances to the facility. The Department makes the monthly Medicaid payment to the facility and recovers the remainder of the child's unearned income to offset the cost of care. If the child has earned income, or if the child has unearned income and someone other than the Department is payee, the facility IM worker shall notify the facility that the facility is responsible for securing the client participation.

Child's Personal Allowance

Policy

All Medicaid-eligible children in a PMIC shall retain $30 of their monthly income for a personal needs allowance. If the child has earned income, an additional $65 is added to the ongoing personal needs allowance from earned income only.

Comment

Children placed in PMICs may continue to maintain a foster care escrow account in the Foster Care Recovery Unit in the Bureau of Finance. Workers shall continue to follow procedures in XIII-J(2) regarding use of foster care escrow accounts.

Legal reference: IAC 441—85.4(1)

Procedure

The IM worker is responsible for calculating the personal needs allowance and for notifying the child (or the child's representative) and the facility of the amount. The Bureau of Finance sends the personal needs allowance to the facility when the Department receives the income for the child.

The facility is responsible for maintaining the child's personal needs allowance in a separate account and for making it available to the child.

MEDICAL COVERAGE FOR CHILDREN IN FOSTER CARE

COVERED SERVICES (Cont.)

Psychiatric Medical Institutions for Children (Cont.)

Child's Personal Allowance (Cont.)

Procedure (Cont.)

Decisions regarding plans for the use of the child's personal needs allowance shall be made by he facility, in consultation with the service worker and child when appropriate.

IFMC Level of Care Review

Policy

The Iowa Foundation for Medical Care shall determine the medical necessity of a child's continued stay in a PMIC. Medicaid payment shall not be approved for stays beyond the time at which care has been determined not to be medically necessary.

Comment

Legal reference: IAC 441—85.8(1)

Procedure

IFMC periodically reviews the child's need for PMIC care. The frequency of the review depends on the child's condition and on the anticipated length of cars in the facility. IFMC notifies the facility and the service worker of the decision. The facility notifies the facility IM worker.

If IFMC determines that the child no longer needs this level of care, the service e worker shall negotiate another placement. This could be a regular foster care placement in that or another facility. If the service worker believes the child still needs this level of care, the service worker can request IFMC to reconsider its decision by writing or calling IFMC (3737) Woodland Ave., West Des Moines, 50265; 515-223-2900).

Medicaid Eligibility Review

Policy

Medicaid eligibility shall be reviewed when there is a change which could affect eligibility, or at a minimum of every six months for ADC—related cases or every twelve months for SSI-related cases.

MEDICAL COVERAGE FOR CHILDREN IN FOSTER CARE

COVERED SERVICES (Cont.)

Psychiatric Medical Institutions for Children (Cont.)

Medicaid Eligibility Review (Cont.)

Comment

Legal reference: IAC 441—76.7(249A)

Procedure

If either the service worker or the facility IM worker learns that the child's eligibility for SSI begins at a point after the initial placement, that worker shall notify the other worker, using form 470-2479, PMIC Exchange of Information. The facility IM worker makes the coding change on the ABC system.

When it is time for the eligibility review, the facility IM worker sends a review form to the person who completed the application. For ADC-related clients, the review form is the Public Assistance Eligibility Report, PA2140-0. For SSI-related clients, the review form is the Application for Medical Assistance or State Supplementary Assistance, PA-1107. The service worker is responsible for getting the form completed and returning it to the facility IM worker, if the parent or relative fails to return the form.

The facility IM worker processes the review and notifies the service worker and the Bureau of Finance of the result, using form 470-2479, PMIC Exchange of Information. The facility IM worker also makes any changes of ABC entries.

Temporary Absences

Policy

Payment will be approved for a maximum of ten days per calendar month during which the child is confined in an acute care general hospital. Payment will not be authorized for over ten days for any continuous hospital stay whether or not the stay extends into a succeeding month.

Payment will be approved for 30 days during which the child is out of the facility at the time of the nightly census for the purpose of a visit. The 30 days can be extended with a service plan approved by the district administrator or designee.

MEDICAL COVERAGE FOR CHILDREN IN FOSTER CARE

COVERED SERVICES (Cont.)

Psychiatric Medical Institutions for Children (Cont.)

Temporary Absences (Cont.)

Comment

The limits on temporary absences for visits and nonpsychiatric hospitalization for children placed in PMICs are those established under the Medicaid program.

For additional information, See VIII-E(2), RESERVE BED DAYS IN PMIC.

Legal reference: IAC 441—85.8(2) and 85.8(3); 85.5(1)"k"

Procedure

The facility and the service worker shall plan jointly for visits.

The facility notifies the service worker of the absence and sends form AA-41266-0, Case Activity Report, to the facility IM worker.

The facility IM worker sends a copy of the Case Activity Report to the service worker, indicating if the number of days exceeds the maximum.

If the number of visit days exceeds the maximum, the service worker shall seek approval from the district administrator or designee and notify the facility IM worker, using form 470-2479, PMIC Exchange of Information, within 10 days.

Runaway or Unplanned Discharge

Policy

The facility shall notify the Department when the child runs away or if there is an unplanned discharge.

Comment

Reserve bed payments "visit days" may be used for days in shelter care or detention, if the child is expected to return to the PMIC.

Legal reference: IAC 441—85.5(1)"k"

MEDICAL COVERAGE FOR CHILDREN IN FOSTER CARE

COVERED SERVICES (Cont.)

Psychiatric Medical Institutions for Children (Cont.)

Runaway or Unplanned Discharge (Cont.)

Procedure

The facility notifies the service worker and sends form AA-4166-0, Case Activity Report, to the facility IM worker. The IM worker sends a copy of the Case Activity Report to the service worker.

If the service worker knows of the child's living arrangement, the service worker advises the facility IM worker, using form 470-2479, PMIC Exchange of Information.

The facility IM worker does an automatic redetermination of future Medicaid eligibility. If the child has entered another foster care placement, the service worker shall change the SRS code and reopen the foster care ABC case. If the child's whereabouts are unknown, the facility IM worker closes the ABC Medicaid case.

Planned Discharge

Policy

The service worker shall notify the facility IM worker, the PLD specialist (or the Foster Care Recovery Unit for those counties not served by a PLD specialist), and the Bureau of Finance as soon as the service worker becomes aware that the child will be discharged from the PMIC.

Comment

This includes changes from a PMIC program to a group foster care program within the same agency or facility.

Procedure

The service worker shall use form 470-2479, PMIC Exchange of Information, for this notification. The service worker shall send the notification in advance of the discharge whenever possible.

The facility IM worker closes the ABC case for paying the facility for the child's care and sends notice to he person designated by the service worker. The facility IM worker shall do an automatic redetermination of future Medicaid eligibility.

MEDICAL COVERAGE FOR CHILDREN IN FOSTER CARE

COVERED SERVICES (Cont.)

Psychiatric Medical Institutions for Children (Cont.)

Planned Discharge (Cont.)

Procedure (Cont.)

If the child is entering a foster care placement in the same or another facility, the service worker shall change the SRS service code and open an ABC foster care case.

Payment-Only Cases

Policy

Juvenile court staff shall fulfill the role of the service worker in the procedures described whenever a juvenile court officer has custody of the child.

Comment

Each district shall establish a mechanism for coordinating the procedure described above for payment-only foster care cases.

Procedure

Staff from the PMIC shall fulfill the role of the service worker in the procedures described above when the facility has custody of the child. The IM worker assigned to the facility provides the family copies of forms 470-2479, PMIC Exchange of Information, and PA-2207-0, Public Assistance Application.

The Department service worker shall enter such cases in the Service Reporting System as payment-only cases.

Waiver Respite Care

Policy

The Department has received approval from the federal government to operate a model program designed to reduce Medicaid institutional costs by paying for home-based and community-based services as an alternative to care in a medical institution. Among the services which can be offered under the waiver for ill and handicapped persons is placement in a licensed foster care facility for respite care.

MEDICAL COVERAGE FOR CHILDREN IN FOSTER CARE

COVERED SERVICES (Cont.)

Waiver Respite Care (Cont.)

Comment

Payment procedures for this service differ from those used for other foster care services. The service worker does not pay the maintenance through the ABC system, nor does the worker make entries on the Service Reporting System to authorize Purchase of Service. Foster care funds, including Title IV-E funds, are not used to pay for the service. There is no parental liability determination by the service worker.

The income available to the child is used to pay for Medicaid waiver services, up to a limit established by the IM worker. Available income may include contributions from the child's parents. Diversions are made for self support and unmet medical needs. The client participation is paid directly to the provider of services. Medicaid payment is made only for the portion of the cost which is not covered by client participation or third-party payment.

Under the waiver, Medicaid pays for foster family home maintenance costs for respite care at the per diem rate used for emergency care. Under the waiver, Medicaid pays for both the maintenance and service costs of a respite care placement in a foster group care facility at the current rate listed for the provider in the Purchase of Service Rate Listing, Report S472 T250.

Because respite care is by nature a short-term placement (limited to 30 days in a 12-month period) there is no payment for reserve bed days.

Legal reference: IAC 441--83

Procedure

See XVI-K(1) for information on eligibility determination, case plan requirements, and other policies.

All providers (both foster families and foster group care facilities) who want to provide respite care under the Medicaid waiver program must apply to Unisys, the Medicaid fiscal agent, for a Medicaid vendor number. Providers will receive a Medicaid Provider Manual for Model Waiver Services. (See VIII-A-Appendix (II) for a copy.) Providers shall submit a bill for Medicaid waiver respite care each month, using form 470-2486, Claim for Targeted Medical Care. Providers must submit the invoice even if client participation or third-party payment covered the cost of the waiver service.

MEDICAL COVERAGE FOR CHILDREN IN FOSTER CARE

SERVICES NOT COVERED BY MEDICAID

Policy

When a child in foster family care has expenses for transportation to receive medical care which cannot be covered by the Medicaid program, the expenses may be paid from foster care funds, with the approval of the district administrator. The claim for all the expenses shall be submitted to the Department on a Claim Order/Claim Voucher within 90 days after the trip. This payment shall not duplicate or supplement payment through the Medicaid program. The expenses may include the actual cost of meals, parking, child care, lodging, passenger fare, or mileage at the rate granted state employees.

Comment

Occasionally a child in foster care requires medical services which are not covered by the Medicaid program. This is a rare occurrence because of the comprehensiveness of the Iowa Medicaid program. Examples include treatment provided in another state by a medical provider who is not an Iowa Medicaid vendor and refuses to become one, excessive expenses for nonprescription drugs if the foster family is not receiving a special care allowance to cover this expense, and certain hospital costs.

In the case of noncovered hospital costs, the hospital is required to receive Department approval before providing a noncovered service. The worker shall obtain the district administrator's authorization before approving a noncovered service. This method of payment shall not be used for hospital bedroom slippers or other amenities, or for educational programs provided by hospitals.

Legal reference: IAC 441--156.8(3), 156.8(4)

Procedure

The worker shall first investigate other sources of payment, including the child's parents and the child's escrow account.

If necessary, the worker shall prepare a Claim Order/Claim Voucher according to instructions in XIII-J-Appendix. The worker shall submit the claim to the Division of Adult, Children and Family Services, with a cover memo explaining the expense and the other payment sources investigated.

Child Hospitalized Before Placement

Policy

Medicaid eligibility shall not be granted on the basis of foster care payment responsibility before a child is actually placed in foster care.

MEDICAL COVERAGE FOR CHILDREN IN FOSTER CARE

SERVICES NOT COVERED BY MEDICAID (Cont.)

Child Hospitalized Before Placement (Cont.)

Comment

Occasionally, a child is removed from the home pursuant to a court order but requires hospitalization before entering foster care. Until the child is actually placed, the child is not considered to be a foster child and is not eligible for Medicaid on that basis. For example, the child could not be determined IV-E-eligible, because no maintenance payments are being made. The child must establish eligibility under a non-foster-care Medicaid coverage group.

When a child is hospitalized before placement and no foster care maintenance payment is being made, the service worker shall send the completed application to the local IM worker to make a Medicaid eligibility determination. If it is determined the child is not eligible for a federally funded Medicaid coverage group, the IM worker shall deny application.

A case providing state-only Medicaid shall not be established in this situation.

The service worker shall instruct the provider to seek payment through the Juvenile Justice Payment System by submitting a Claim for Court-Ordered Care and Treatment, form 470-1691, to the Division of Adult, Children, and Family Services. Each claim shall be accompanied by an original and two copies of the signed and completed Authorization for Payment of Court-Ordered Care and Treatment, form 470-2609, and court documentation.

The claim must be submitted within three months of the date of service. Claims submitted more than three months after the services were provided must go through the State Appeal Board to be paid. Exceptions to this policy are when claims are submitted more than three months after the services were rendered because the provider was waiting for a Medicaid eligibility determination or an insurance payment to be made.

EXAMPLES

1. Kelly, age 3, was removed from her home by court order due to reported child abuse. Medical care was court-ordered. Since she required hospitalization for treatment of her injuries, Kelly did not immediately enter a foster care placement. Since Kelly is not actually in foster care, she does not meet the requirements of IV-E. The IM worker establishes that she meets the requirements of CMAP. When Kelly actually enters foster, her IV-E eligibility is examined again.

MEDICAL COVERAGE FOR CHILDREN IN FOSTER CARE

SERVICES NOT COVERED BY MEDICAID (Cont.)

Child Hospitalized Before Placement (Cont.)

Comment (Cont.)

EXAMPLES (Cont.)

2. Same as example 1, except Kelly is not eligible under a federally funded Medicaid coverage group. State-only medical coverage shall not be provided, since Kelly is not in a foster care placement. Again, Kelly's Medicaid eligibility shall be redetermined when she enters foster care.

When the child enters a foster care placement, a new Medicaid application shall be completed and Medicaid eligibility shall be re-examined. If there has been no change in the child's circumstances and the child is still ineligible under a coverage group for which federal financial participation is available, Medicaid with state-only funding shall be provided.

Legal reference: IAC 441--76.1(10) and 202.1(234)